

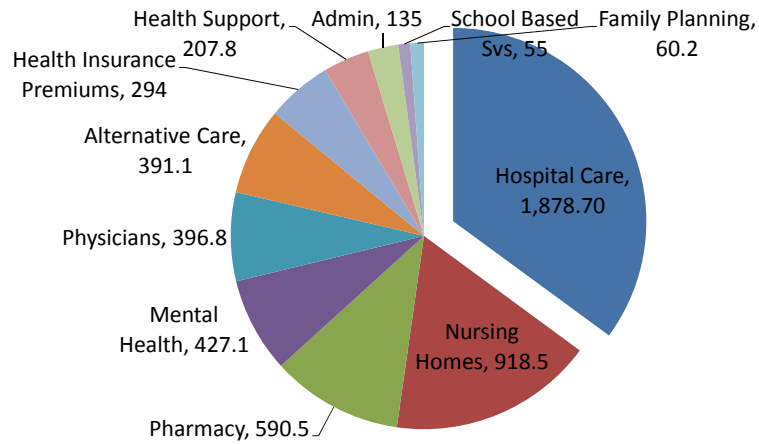
Medicaid

A Time for Change

Insanity

Doing the same things over and over again and expecting a different result

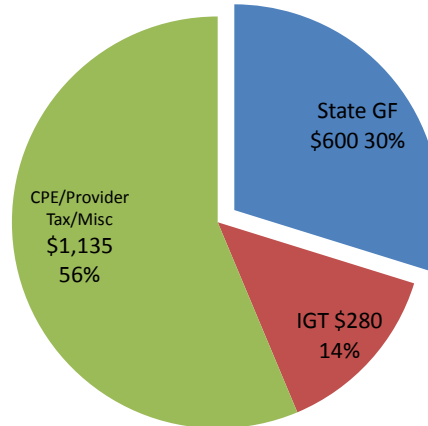
Medicaid Expenditures FY 12 in millions



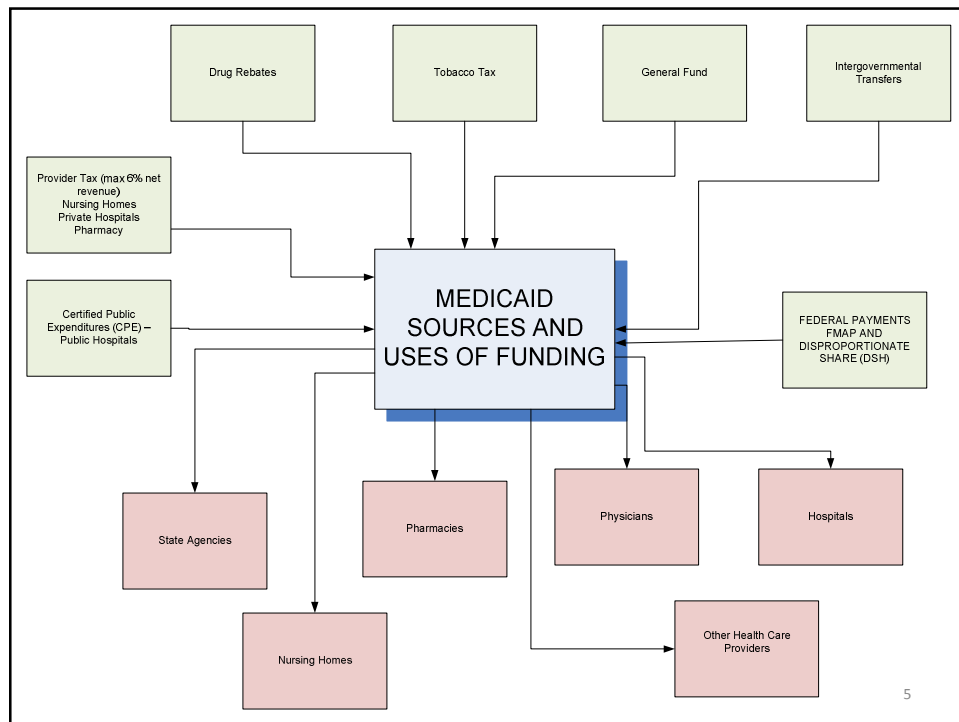
3

- Federal FMAP provides \$3.627 billion (67.6%)
- State share \$1.735 billion (32.4%)
 - \$880 million provided by the state general fund, tobacco taxes, and IGT
 - Remainder is hospital CPE, drug rebates, and provider taxes
- Hospital CPE is, by far, the largest, most complex non tax resource

STATE SHARE BY SOURCE



4



Summary of Current Financing System

- No state funds used in the hospital program
- About 1/3 of state match provided by GF
- 1/3 of nursing home cost funded through NH provider tax
- > 1/3 of pharmacy cost paid by provider tax and drug rebates
- Almost all mental health cost paid by IGT from DMH

- Reductions in hospital utilization do not reduce state expenditures
- Provider taxes for hospitals and nursing homes are near maximum levels
- CPEs are an estimate of cost not reconciled for 2-3 years
- Alabama has through use of CPE, IGT, provider taxes, etc., converted a 2:1 match into an effective match of 9:1 for Medicaid's GF appropriation
- Due to inelasticity in non GF sources, an increase in funding need falls disproportionately onto the GF

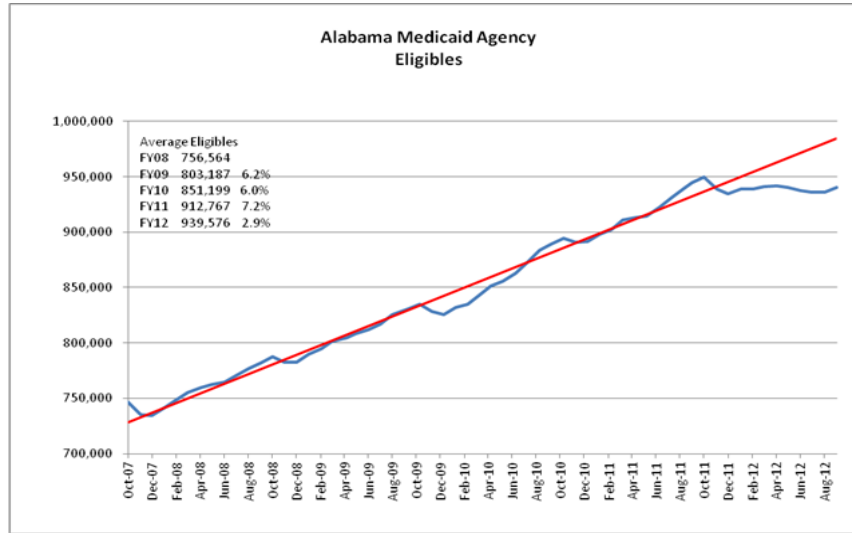
7

Reasons for Change

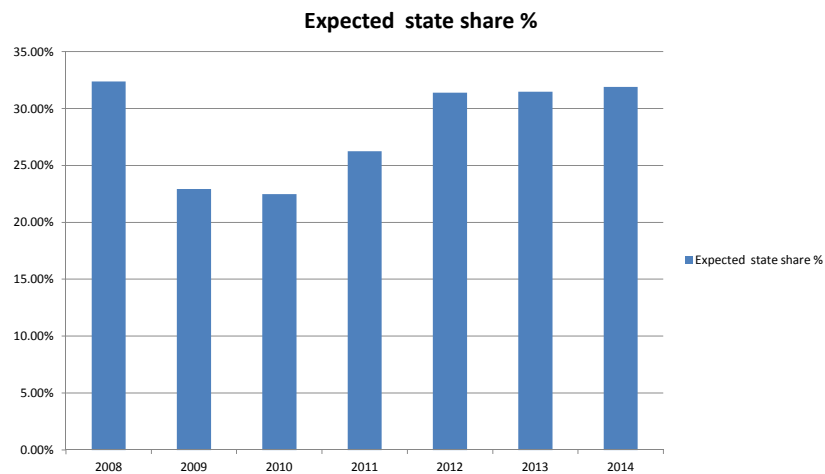
- Unsustainable financing model
 - Relies on CPEs, provider taxes, IGTs, and drug rebates as primary source of state funds
 - CPE methodology is complicated and lacks transparency
 - Use of CPEs creates potential unfunded liabilities due to future reconciliations
 - Medicaid with 24% growth in enrollees and 27% growth in expenditures from 2008-2012 consumes progressively larger portions of the GF
 - With no new initiatives in 2014, Medicaid would require > \$90 million new state funds

8

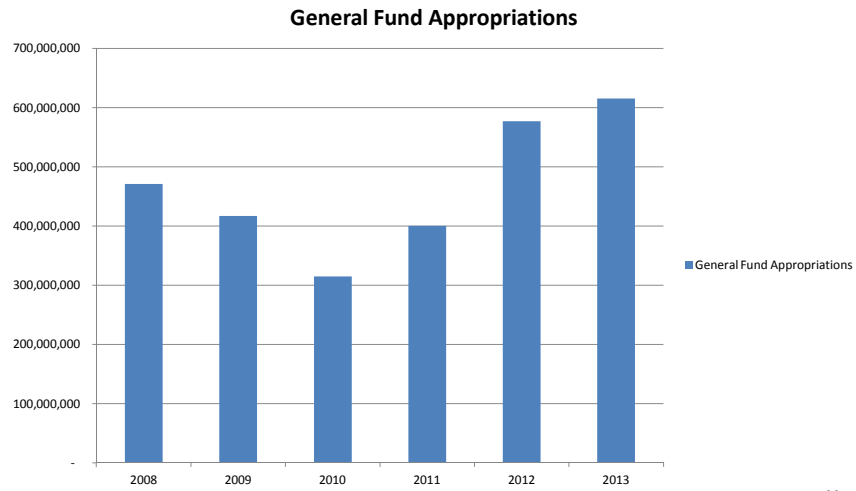
Eligibles Grew From FY08 to FY12 by 24%



State Share in FY2009-11 Subsidized by ARRA

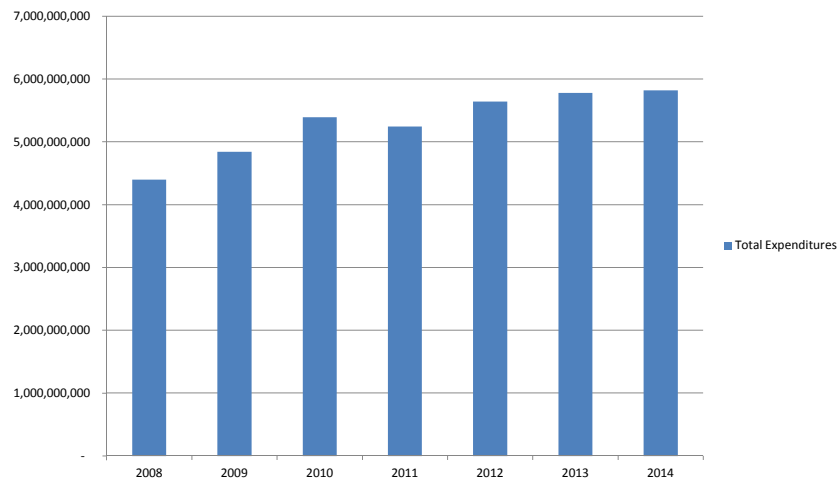


General Fund Appropriations Vary Based on Total Spend and FMAP

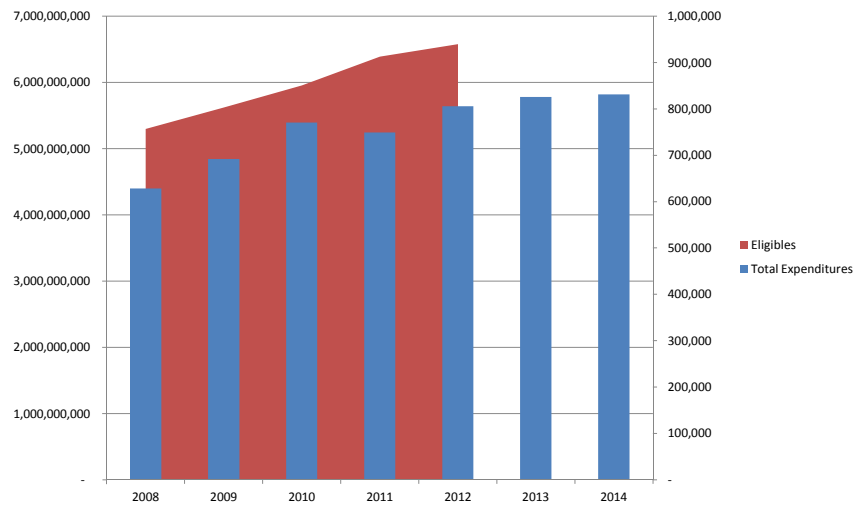


Total Medicaid Expenditures

FY08-12 Actual / FY2013-14 Est



Growth In Total Medicaid Spending Driven by Increase in Eligibles



13

- Expiration of hospital provider tax (\$229m) and nursing home tax (\$55/\$105m) in 2013
- DSH payments decline nationally by > 60% by 2019
- Current hospital funding model encourages utilization to maximize revenue for Medicaid
- Increased primary care reimbursement unfunded in FY15
- No obvious funding source for Medicaid expansion
- Reliance on CPEs and provider taxes limits innovations
- Unfunded IBNR of \$375m

14

- Problems with delivery system
 - Reimbursement is volume driven, not quality and outcome based
 - Over utilize admissions and ER visits
 - No incentives to integrate and coordinate outpatient care
 - Under utilize community based long-term care solutions
 - Inadequate providers currently available for some Medicaid populations
 - Lack of providers for expansion

15

Total Hospital Utilization

Indicators per 1,000 Population	Alabama	United States	Percent Differential
Admissions	134	114	17.5%
Emergency Room Visits	482	411	17.3%
Inpatient Days	697	613	13.7%
Outpatient Visits	1,839	2,106	-12.6%

Source: Kaiser State Health Facts, 2010 data

Barriers in Access to Care

	Alabama	United States
Physicians per 10,000 Population	20.6	25.7
Population Living in a Primary Care HPSA as % of State Population	33.7%	19.1%
Estimated Underserved Population as % of State Population	17.4%	11.4%
Could Not See Doctor Because of Cost	16.8%	14.6%

Source: Kaiser State Health Facts

Hospital Association Project

Areas of Consensus

- The Medicaid Program is underfunded and new money must be made available to the Program.
- The proposed financing/payment model must remove perverse incentives in hospital payments.
- The proposed delivery model needs to:
 - Support additional access to primary care
 - Increase coordination across providers

18

Mission of Reform

1. High quality health care to all Medicaid recipients at the lowest appropriate cost to Alabama tax payers
2. Fair and reasonable reimbursement to providers
3. Sustainable long-term funding stream for Medicaid

19

Goals of a Reformed System

- Integrated care model with linkages between providers
- Reduced unnecessary hospital and ER visits
- Enhanced patient compliance and improved patient outcomes
- Payments shifted from volume driven to accountability and outcome based

20

- Model that provides more predictability in Medicaid's budget
- Payment structure that removes perverse incentives
- Enhanced data system to improve patient management
- System that ultimately shifts some portion of risk from state to third parties

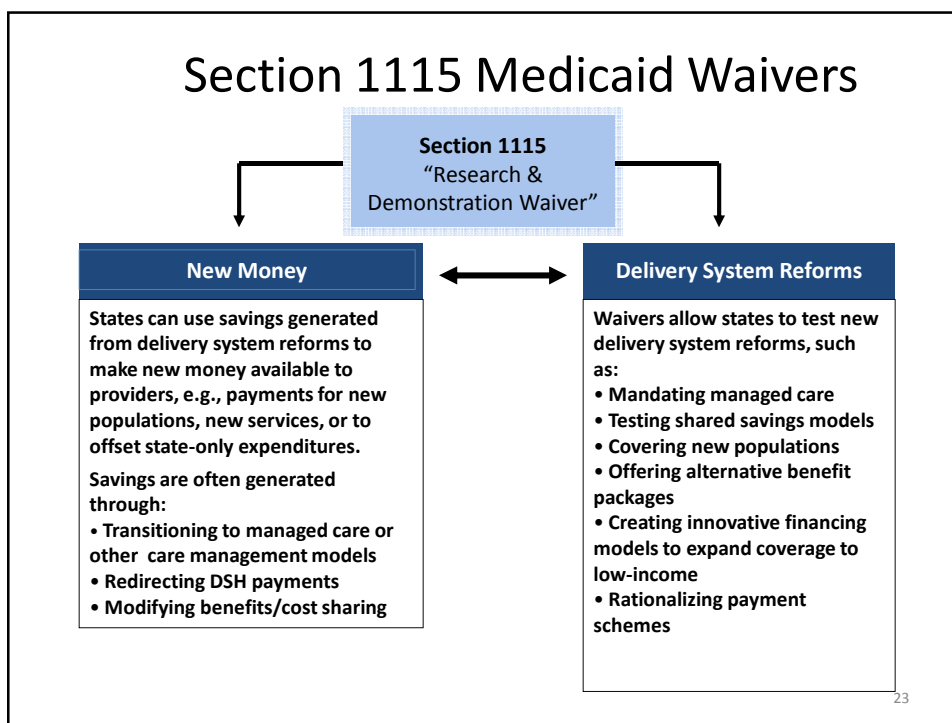
21

Options for Reform

- Political system inspired reform
 - Block grant to states
 - Waivers of current eligibility standards
 - 1115 waiver from HHS to reform the delivery system
- Delivery system reform
 - Commercial managed care
 - ACO
 - Enhanced PCNs

22

Section 1115 Medicaid Waivers



- Financing reform
 - Change in funding and payment for hospitalization
 - Shared risk/reward from payment based on quality of care and outcomes
 - State Medicaid funding tied to rate of medical inflation

Issues in Payment and Financing Reform

- IGTs vs CPEs
- DRGs vs per diem
- Provider tax reauthorization
- DSH reduction
- 1115 waiver
- PBMs
- Risk assumption

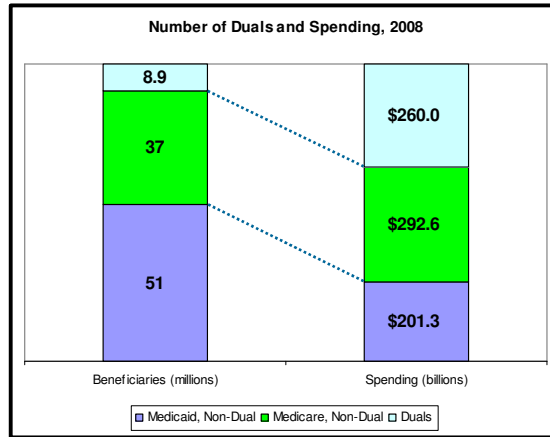
25

Issues in Delivery System Reform

- Need for more robust data to measure outcomes
- Payment incentives to encourage coordinated care and minimize unnecessary utilization
- Ability to incorporate the ABD, dual eligibles and LTC population into one system
- Lack of experience with managed care
- Accurate valuation of potential savings from integrated care

26

Dual Eligibles



- 207,000 duals in Alabama
- \$2.7B Medicare expenditures
- \$1.2B Medicaid expenditures

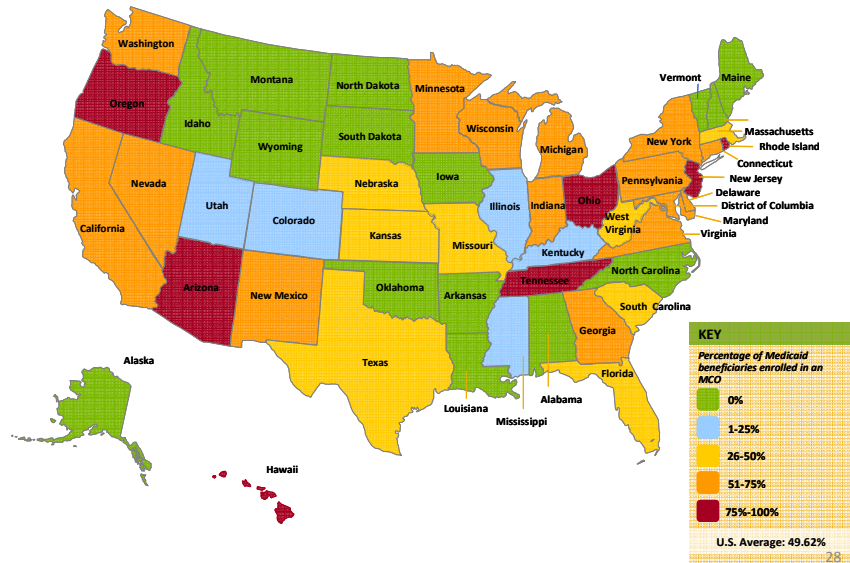
- Duals represent 15% of the Medicaid population but account for 39% of Medicaid expenditures
- Duals represent 20% of the Medicare population but account for 31% of all Medicare spending
- Duals represent 9% of the Medicare and Medicaid population but account for 34% of total spending

Source: Kaiser Commission on Medicaid and the Uninsured, *Medicare's Role for Dual Eligible Beneficiaries*, April 2012.

27

Medicaid & MCOs: Broad Trend to Managed Care

22 states have > 50% of Medicaid beneficiaries enrolled in MCOs



Charge to the Commission

- Analyze the financial needs of Medicaid
- Sustainable financing model that meets budget limits on Medicaid spending
- New delivery models that support quality care and cost control
- Increased transparency and fairness in the system

29

Questions?

Email:

medicaidcommission@medicaid.alabama.gov

For more information, go to:

www.medicaid.alabama.gov and click on the “Newsroom” drop-down menu. The Commission is the second item on the list.

30